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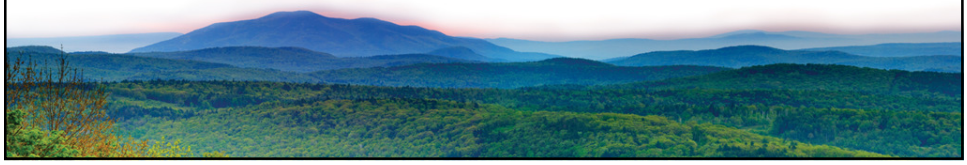
Mt. Ascutney Hospital & Health Center

Budget Presentation

Green Mountain Care Board
August 24, 2017



Presenting

- Joseph Perras, M.D., CEO/CMO
- David Sanville, Chief Financial Officer
- Theresa Tabor, Controller
- Wendy Fielding, Vice President, Financial Planning

  Dartmouth-Hitchcock Health

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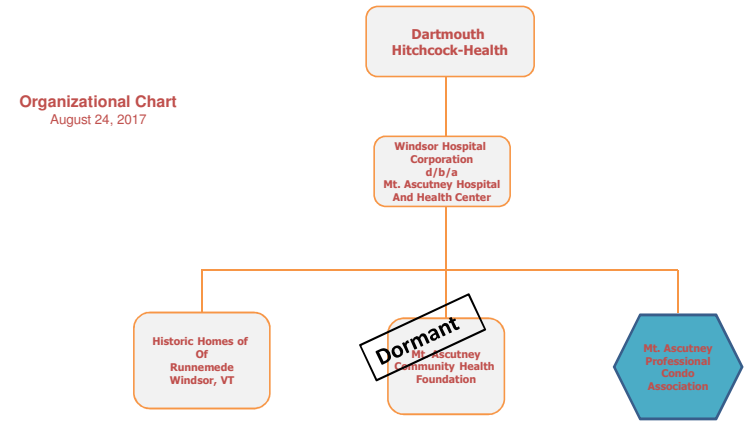
Organizational Chart
August 24, 2017



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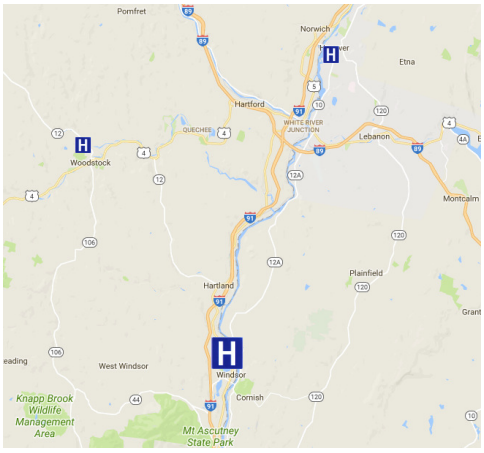
Service Locations
August 24, 2017



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2018 Budget Initiatives

- Support Strategic Planning Commitments
- Support DHH System Initiatives
  - Clinical
  - Administrative
  - Financial
- Establish infrastructure for:
  - Quality expectations (reporting/measures)
  - APM/ACO platform(s)
- Maintain stability

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2018 Capital Budget

- Scopes for OR ($150k)
- Phaco Emulsifier ($100k)
- OR Stretchers/Beds ($200k)
- Routine Diagnostic Imaging Upgrades ($350k)
- Mini C-Arm ($90k)
- Telephone System ($150k)
- Roofing ($200k)
- Rooftop Units ($100k)
- Routine Device and Server Upgrades ($200k)

Major Moveable	$1,887k
Information Technology	$550k
Facility	$782k
Total:	$3,219k

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CON Update

Phase I – Repurpose Nursing Home into Inpatient Rehabilitation Unit
Phase II – Repurpose Rehab Unit into OP Therapy Gym, Pharmacy, etc.
Phase III – Reconfigure Existing semi-private, non-Rehab Acute to Private Rooms
Phase IV – Repurpose OP Therapy to Provider and/or Clinic Space

- All work under the CON is complete
- Within the 3 year timeframe
- Within the 10% allowance.
- Will be submitting final 6 month report following September 30, 2017 close

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CON Update

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Population/Community Health at MAHHC

- **Community Health is embedded in our Mission and Strategic Plan**
- **We have built and infrastructure to operationalize our commitment**
  - Community Health Board Subcommittee
  - Director of Community Health
- **Leadership role in building community networks**
  - Windsor HSA Coordinated Care Committee
  - Windsor Area Community Partnership
  - Windsor Connection Resource Center and PATCH Team
  - Mt. Ascutney Prevention Partnership
  - Windsor Area Drug Task Force
- **Continuum of care from prevention to chronic care management as an Accountable Community for Health**

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MAHHC Response to 2016 CHNA (1/4)

1. Alcohol and drug misuse including heroin and use of pain medications

- Medication Assisted Therapy, counseling, support and case management through Spoke services
  - Internally - Pediatrics & Primary Care
  - Externally - Connecticut Valley Recovery Services & Bradford Psychiatric Associates
  - Led quality improvement projects within each site
- Partnership with Blue Cross Blue Shield and Department of Health Office of Alcohol and Drug Abuse to implement a systematic and ongoing Screening, Brief Intervention and Referral to Treatment (SBIRT) protocol for substance use throughout the clinics and ED
- SBIRT Community Trainings to SASH, spoke staff, Turning Point recovery coaches, HCRS, Court Diversion, White River Family Practice, school staff
- Multidisciplinary Functional Recovery Consult Team for patients with chronic pain

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MAHHC Response to 2016 CHNA (2/4)

2. Access to mental health

- WRAP workshops delivered for skill building and self-management support for anxiety, depression and general mental health
- Expansion of a HCRS embedded clinician/LADAC to four days a week in Patient Centered Medical Home supported by SBIRT grant

3. Access to dental care

- Application of fluoride in pediatric clinics
- Dental vouchers for care through Windsor Community Health Clinic
- Dental clinics in the school
- Community Health Team, Spoke Staff and staff of the Windsor Community Health Clinic assist patients to find dental homes, care and financing

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MAHHC Response to 2016 CHNA (3/4)

4. Access to affordable health insurance, cost of prescription drugs

- Windsor/Woodstock Navigator Program and Windsor Community Health Clinic assistants with Vermont Health Connect, and Medicare and Medicaid applications
- Medicare Boot Camp – March 31, 2017 and July 24, 2017

5. Nutrition/access to affordable food

- Work with the school, three local churches, recreation department, low-income housing, Windsor Connection Resource Center and Windsor Food Shelf to provide Summer Food Program
- Implementation of 3–4–50
- Creation of a family friendly version of Eat Well on $4/day- Good and Cheap cook book created by pediatric staff, AHEC and illustrated by local students.
- Work with Vermont Housing Association and SASH to organize a cooking matters class for residents at low income housing

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MAHHC Response to 2016 CHNA (4/4)

6. Lack of physical activity, need for recreational opportunities and active living

- Implementation of 3–4–50, now looking to RISE VT

7. Income, poverty and family stress

- PATCH services at the Windsor Connection Resource Center from October 2016 through September 2017 include visits for economic services, visits for mental health counseling and visits for employment counseling
- Parent-to-Parent Collaborative Problem-Solving Programs
- A Family Wellness Program has been embedded in the pediatric clinic based on the research effective Vermont Family-Based Approach
- Windsor has been identified as a
- Promise Community - to promote kindergarten readiness and emotional and social competence of children and families

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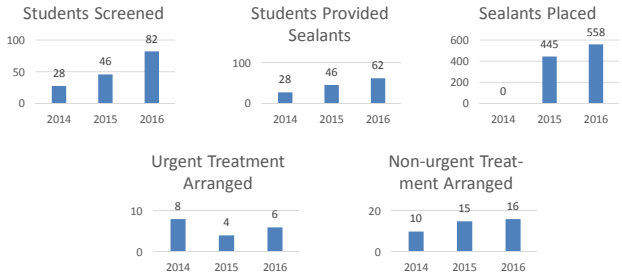
Community Health Needs Assessment Examples of Outcomes – Access to Dental Care

- Dental Clinics Provided in the Schools



- Pediatricians provide oral risk assessments and fluoride applications during well-child visits from age 6 months to 5 years

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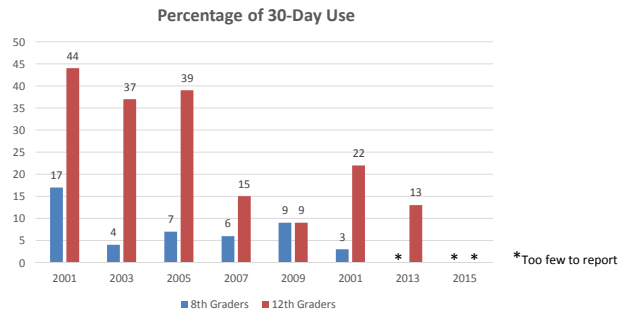
Community Health Needs Assessment
Examples of Outcomes – Tobacco Prevention



- Programs provided—prevention education, youth training for peer-to-peer outreach, Vermont Kids Against Tobacco (VKAT), Kick Butts Day, Tobacco Litter Campaign and Counterbalance

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Budget Analysis Questions #1

Narr – Mt. Ascutney and DHMC have been reorganizing and formalizing the relationship over the last few years. Describe the status of this agreement and explain how it has changed Mt. Ascutney's role in the health care system. Describe the opportunities and risks related to this new agreement.

- **July of 2014, MAHHC affiliated with Dartmouth-Hitchcock Health.**
- **Work for the strategic, clinical and operational integration is ongoing**
- **Affiliation has benefited both hospitals w/unintended consequences too**
  - Recruitments of medical specialists and key managers
  - Resources & academic opportunities help recruitment
- **Allows us to keep the care of our patients closer to home**
- **Implemented 24/7 tele-health support**
- **Implementing 24/7 tele-psychiatry services**
- **Since 2014, we have taken 1500+ post-acute patients from DHMC**
  - Largest recipient of this class of patients from DH in either NH or VT.
  - "Decompressing DH" while focusing on one of our core strengths

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Budget Analysis Questions #1 (con't)

Narr – Mt. Ascutney and DHMC have been reorganizing and formalizing the relationship over the last few years. Describe the status of this agreement and explain how it has changed Mt. Ascutney's role in the health care system. Describe the opportunities and risks related to this new agreement.

- **From a clinical perspective, the risks:**
  - Potential for DH to "pull back" clinical services when there are needs at DH
  - This is a difficult experience for referring primary care providers and patients.
- **Engaged with D-HH's departments of Finance, HR, Materials Management, Media Relations, Development, and Nursing.**
  - All have contributed to our bottom line
  - All have improved our ability to more effectively meet our mission.

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Budget Analysis Questions #1 (con't)

Clinical

- Quality and Safety program consistency and governance
- Short-term loss of some surgical and medical specialties; other services coming with goal of all non-tertiary care staying in community
- Gains of managerial candidates to support ancillary services

Finance

- Refinancing of debt, savings on interest
- Financial analyst services
- Payroll, billing (future)

Human Resources

- Harmonizing policies & procedures
- Centralizing recruitment services
- Salary & Benefits (future)

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Budget Analysis Questions #1 (con't)

Care Management Changes

- Increased efficiency in patient care throughout the D-HH system
- The right care at the right place, with the best outcomes, for the lowest cost.
- Move toward common EMR across the system in 2019
- Integrated models of care across the smaller affiliate hospitals

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Budget Analysis Questions #2

Income Statement – The hospital is $0.6 million, or 1.4% over the 2017 budget levels and within the Board's 3% target. As part of being able to make the target, the hospital has budgeted an operating loss of over $1 million. There are able to do this since DHMC will provide a subsidy to support cash flow needs. Describe this arrangement with DHMC and when the hospital will begin budgeting a surplus?

- MAHHC budgeted a $1.2m loss for FY17 and a similar loss for FY18.
  - D-HH provides a "System Allocation Payment" $1.2m due to:
    - Integration, allocating and re-allocating services within DH takes time
    - Benefit of our willingness to take sub-acute patients
    - MAHHC is an early adopter of the system's initiatives
    - This payment makes up for the impact these issues
    - Negative operating margin but total margin is like a break-even hospital
    - This allows us to maintain a reasonable balance sheet
    - Invest appropriately in the areas of mission, staff, and capital needs.
  - It is unclear how soon a normal operating margin of 2-3% would be possible.

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Budget Analysis Questions #3

Rate & NPR – Mt. Ascutney has an overall rate/price request of 4.89%. Discuss the rationale and other factors that explain the reason for your price/rate increase, including the changes occurring in utilization.

Our budgeting process drives our rate request each year

- Volumes drive staffing levels and variable expense
- Inflation factors, wage increases, etc. are added to expense
- Changes in payer mix, payer contracts, governmental reimbursement, and the impact on our CAH cost report are studied and added
- These factors are entered into our budget model to calculate current pricing with the projected volume.
- Our gain or loss on operations is determined and we increase our prices until we reach the desired margin.
- We have had a fairly predictable utilization in "inpatient" lines of business
- B2B, we budgeted for a reduction in ER, primary care, and ancillaries

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Budget Analysis Questions #4

NPR Payer – Medicaid shows unfavorable reimbursement and loss of utilization from 2017 to 2018 budget. Describe the reimbursement assumptions the hospital has made. Also, describe what is happening with Medicaid utilization.

- **Overall utilization is down, budget to budget.**
  - In the areas of clinics and outpatient ancillaries.
  - Recent struggles in primary care
  - System service allocation initiatives at D-HH
- **Therefore, utilization in all payer mix groups is diminishing**
- **YTD, Medicaid has been running lower as a percentage than in the past**
  - No blatantly obvious reason for this
  - Patient access in primary care
  - Changes in N.H. Medicaid administrators

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Budget Analysis Questions #5

Income Statement – Retail pharmacy (340B) of $725,000 is recorded in operating revenue. Describe this program and the risks involved operating the program.

We actually utilize three opportunities in the 340B arena due to CAH status.

- **As a covered entity, able to purchase many meds @ lower prices**
- **340B in outpatient settings**
  - Lowers our cost to operate in those areas
  - Helps us reduce the request for price increases
  - Worth $150,000 in savings per year in our supply costs.
- **340B for our employees via mail order**
  - Lowers our operating costs since we are self-funded
  - Savings passed on to our employees as well
  - Reduces our costs to the patients, insurers, and employers.
  - This aspect of the program is worth $100,000 per year in benefits

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Budget Analysis Questions #5 (con't)

Income Statement – Retail pharmacy (340B) of $725,000 is recorded in operating revenue. Describe this program and the risks involved operating the program.

- **340B retail pharmacy program: qualified patients, get qualified med, from qualified provider, @ qualified retailer**
  - Med is purchased at a lower cost by retailer (using 340B)
  - Retailer is paid to administer the transaction, inventory, & billing
  - Margin created by the lower purchasing cost is remitted to hospital
  - The net (revenue less all costs) is booked in Other Operating Revenue
- **Hospital is able to offset the effect of the cost shift**
- **New source of revenue at no add'l cost to patient, insurer, and employer**
- **Allows hospital to run high-subsidy services for community**
- **The risk is that this program is not popular with "big pharm"**
- **Hospitals & state leveraged to get needed margins & balance sheet position**
  - MU diminishing & if 340B goes away, no way to cover operating expense
  - NPR pie shrinks every year with no viable way to replace

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Budget Analysis Questions #6

Income Statement – Are the 2017 projections still valid? If not, please describe material changes?

- **We submitted a $288k positive margin vs budgeted margin of -$1.2m.**
- **We expect an improvement from this, a positive operating margin of $650k.**
  - Our self-funded health insurance is running 20% below actuarial expectations.
    - We expect that this will continue through the end of year
  - Supplies are trending towards a $400k favorable variance
    - Lower volumes in outpatient settings
    - Access to D-HH supply chain pricing
  - Depreciation is favorable ($400k)
    - Purchasing less capital than anticipated
    - DH Affiliation Fair Market Adjustment depreciation beginning to be "retired".
  - Continued favorable payer mix & bump from cost report

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Budget Analysis Questions #7

Refer to the Act 53 price and quality data schedules that were included in the presentation of FY 2018 Hospital Budget Submissions-Preliminary Review on July 27, 2017 and be prepared to address questions the Board may have concerning that information.

Acknowledged.

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Budget Analysis Questions #8

In the March 31 GMCB hospital guidance, the Board allowed up to 0.4% for new health care reform. The Board directed each hospital to provide a detailed description of each new health care reform activity, investment or initiative included within the designated 0.4%, provide any available data or evidence-based support for the activity's effectiveness or value, and identify the benchmark or measure by which the hospital can determine that the activity reduces costs, improves health, and/or increases Vermonters' access to health care. With this in mind, please describe how you are investing for new health care reform activities in the four approved areas:

- **Support for Accountable Care Organization (ACO) infrastructure or ACO programs;**
- **Support of community infrastructure related to ACO programs;**
- **Building capacity for, or implementation of, population health improvement activities identified in the Community Health Needs Assessment, with a preference for those activities connected with the population health measures outlined in the All-payer Model Agreement;**
- **Support for programs designed to achieve the population health measures outlined in the All-payer Model Agreement.**

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Budget Analysis Questions #8 (con't)

All of the health care reform costs are baked into our budget and operations.

Support for ACO infrastructure or ACO programs

- We created a director position for Quality and Patient Safety
  - Developed a Quality Dashboard that shows progress toward ACO quality goals
  - We provide a stipend for PCP's to develop/implement QI projects for OCV quality metrics
  - In 2017 we completed a project that reduced COPD admissions to MAHHC
  - In 2018 we plan to design a program to reduce CHF admissions

Support of community infrastructure related to ACO programs

- We provide the leadership and infrastructure for the Windsor HSA.
  - Quarterly meetings with SNFs, SASH, VNA, Designated agencies and community resources
  - Created a senior leadership level Director of Community Health & Outreach
    - Focus is to implement the Community Health Needs Assessment
    - Design programs in response issues identified

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Budget Analysis Questions #8 (con't)

Building capacity for population health improvement activities

- Hired data analyst to report real-time performance of APM measures
- Hired a nurse informaticist to optimize data entry/extraction from EMR
- Retrained nursing staff in clinics to allow for practice at the tops of their licenses

Support of Programs designed to achieve the population health measures

- 3-4-50 Program over the last year & moving to adoption of the RiseVT
- Ongoing outreach & classes to address tobacco use/intervention
- Initiated SBIRT in clinics and ER for early intervention on alcohol and drugs
- Meet the goal of 30 day follow up for mental health care after ED/hospital visit
- Set up patient experience committee to address CG CAHPs and HCAHPS scores
  - Hand Hygiene, Noise reduction, and provider communication
- Six Sigma Green-belt project with the Dartmouth Value Institute
  - Improve documentation and work-flows for vaccination administration
- Working to develop real-time reporting on hypertension control and HbA1c measures

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Budget Analysis Questions #9

Please identify which ACO(s) you will have a contractual relationship with in 2018. If your hospital plans (or already is) in a risk-bearing contract with OneCare, please explain the effect of the risk on your financial statements. Please explain specific strategies your hospital is developing to move toward population-based payment reform. Finally, what tools does your hospital employ to ensure appropriate, cost effective, quality care when working with providers outside the CHAC or OneCare network?

For 2018 we are likely to engage with Vermont Medicaid Next Gen ACO

- We are awaiting more details AND will review the experience of Porter
- We continue to have questions regarding risk contracting
- Concerned with interface of cost-based reimbursement as a CAH and ACO
- We may move to full risk with OCV in 2019 if questions are answered.
- All tertiary care required by MAHHC patients is provided by DHMC
  - Highest spend patients receive their care at non-risk bearing facility
  - Puts MAHHC in a tough position so we work to keep our patients local
  - Working with DH to provide specialty care in Windsor to control costs
  - Working with DH to ensure that patients move to MAHHC ASAP

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Health Care Advocate Questions #1

What are the hospital's goals for participation in payment reform initiatives in 2018 and in the next five years?

a. What steps will the hospital take to meet these goals?

b. Please describe the reasons why the hospital has chosen not to participate in the risk- based Accountable Care Organization payment models offered to date. If the decision was informed by financial modelling, please provide the model specification, model inputs and results.

c. Does the hospital participate in any capitated payment agreements directly with insurers? If yes, please describe:

i. Whether the capitated payments save the insurer money compared to fee for service payments;

ii. Whether the hospital and/or its providers earn more profit under capitated payments or fee for service, on average; and

iii. How the hospital ensures that patients continue to receive appropriate services under capitated payments.

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Health Care Advocate Questions #1 (con't)

Likely to engage with Vermont Medicaid Next Gen ACO

- Need more details about the program AND experience of Porter
- Have questions regarding risk contracting and the interface with cost-based reimbursement as a CAH.
- Likely move to a full risk model with OCV in 2019 if questions answered
  - Health care consulting firm to help us model potential solutions
- All tertiary care required by MAHHC patients is performed by DHMC
  - Highest spend patients receive their care at non-risk bearing facility
  - Challenging position
    - Work diligently to keep our patients local
    - Maintain our strong hospitalist program
    - Work with DH to provide specialty care in Windsor to control costs
    - Work with DH to ensure that our patients quickly move to MAHHC once their tertiary needs are met at DHMC.
- We do not participate in capitated payment agreements directly with insurers

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Health Care Advocate Questions #2

Please describe the financial incentives that the hospital currently includes in provider, coder, and other personnel salaries and/or contracts.

a. How has the use of incentives by the hospital changed over time?

- Standard practice is NOT to offer financial incentives for our staff, managers, and providers.
- We do have a few providers whose contract terms are "grandfathered"
  - Only providers have received incentives and those incentives were based on productivity, quality, and customer satisfaction.
  - Three providers still have an incentive based on those items
  - We have five providers who are paid based on average daily census targets

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Health Care Advocate Questions #3

Does the hospital or any of its departments or personnel receive financial or other benefits for using specific pharmaceuticals?

a. Please list all pharmaceuticals for which the hospital or provider receives payment when the drug is prescribed, administered, and/or when the prescription is filled.

- The hospital does not receive direct or indirect benefit, financially or otherwise, for administering any specific pharmaceutical
- We have group purchasing arrangements that offer discounts to the hospital for purchases from certain distributors.
- Most distributors offer access to nearly all pharmaceuticals.
- No specific products have any such incentive

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Health Care Advocate Questions #4

With the various payment reform initiatives underway, shared decision-making is becoming increasingly important as an antidote to the potentially perverse incentives of risk-based payment models.

a. Do you commit to implementing shared decision-making throughout your hospital system in 2018?

b. Please describe your plan for doing so and how you will measure the plan's implementation progress.

- We focus on primary care, acute/urgent general surgery and post-acute/acute rehabilitative services
- We engage in routine shared decision making for our interventions
- On our inpatient units we perform IN-ROOM rounding for patients, a multidisciplinary approach with patients and their families
  - Outline the plan of care, upcoming interventions, and discharge planning
  - We measure our success by our patient experience surveys (HCAHPS).
- We do not perform major surgeries, i.e. joint replacements, cardiovascular procedures and prostate/breast cancer surgeries which have established shared decision making protocols.

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Health Care Advocate Questions #5

What is the extent of your Choosing Wisely initiative(s), if any? Please describe the initiative(s), how you have chosen which departments participate, and which of these initiatives, if any, have led to identifiable cost savings and/or quality improvement.

Purpose of Choosing Wisely is to promote providers & patients choosing appropriate care that is supported by evidence, is not duplicative, is free from harm, and is truly necessary.

- Expanded hospitalist service and education/outreach
  - Reduced lab and radiology procedures by 10-15% over the last 3 years.
- Specific Choosing Wisely activities:
  - Reduction of indwelling urinary catheters - no infection in 12 months
  - Not treating asymptomatic bacteriuria in older adults without specific UTI
  - Eliminated feeding tubes for IP's w/ advanced dementia, perform assisted oral feedings
  - Implemented antibiotic stewardship program to limit use of antibiotics
  - Reduced the use of flouroquinolones to reduce rate of c. diff infection to zero
  - Lowered transfusion threshold to 7.0 g/dl, lowering blood product usage
  - Limit radiation exposure for patients with suspected appendicitis

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Health Care Advocate Questions #6

Please provide copies of your financial assistance policy, application , and plain language summary as well as detailed information about the ways in which these three items can be obtained by patients.

a. Please provide the following data by year, 2014 to 2017 (to date):

i. Number of people who were screened for financial assistance eligibility;

ii. Number of people who applied for financial assistance;

iii. Number of people who were granted financial assistance by level of financial assistance received;

iv. Number of people who were denied by reason for denial.

- Submitted copies of the policy, the plain language summary, and our application
- Plain language document outlines the methods of initiating an application
- Below is the summary data requested in i., ii., iii., and iv. above.
- Note that we do not file or track denials by year
- Note that we have annualized FY17 based on data through June 30, 2017.

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Health Care Advocate Questions #6 (con't)

Financial Assistance Approval Statistics

Year	25%	50%	75%	100%	Total #	Denied	Total Screened
2014	8	10	16	372	406		
2015	7	7	18	270	302		
2016	5	19	13	221	258		
2017 Projected	7	9	9	177	202		
Total:					**1,168**	**207**	**1,375**

Financial Assistance Denial Statistics (FY14 - 3rd Qtr FY17)

Reason	Total #	% of Denials
Incomplete Application	111	54%
Over Income	78	38%
Assets	8	4%
Insurance Available	7	3%
Not Resident of Service Area	3	1%
Total:	207	
% Denied of Total Screened	15%	

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Health Care Advocate Questions #7

As a nonprofit with a duty to benefit the community, how does the hospital ensure that its commercial rates are in the best interest of consumers? Please provide specific metric(s) that the hospital uses to determine this. For any metric(s) currently in use for this purpose, please provide results by year for 2014 to 2017 (to date).

See answer to #8

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Health Care Advocate Questions #8

We often hear from hospitals that they charge extra for a wide variety of services in order to fund core hospital services. In light of this business model, how does the hospital ensure that the prices of its services are set appropriately?

a. **What factors are considered in setting prices?**
b. **What financial or quantitative metrics does the hospital use to ensure that its service pricing is appropriate? For any metric(s) currently in use for this purpose, please provide results by year for 2014 to 2017 (to date)**

- Our budgeting process drives our rate request each year.
- Relative to how price increases are applied across the departments and services…
  - First general concept is that provider services are paid on a fee schedule with an inflator
  - Provider charge increases greater than 3 or 4% create "unreimbursed" revenue
  - We try to keep increases to pricing in that service area below those levels
  - The rest of the revenue needed to make the necessary margin will come from the hospital services

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Health Care Advocate Questions #8 (con't)

- Old/existing charges are inherited and are baked into the revenue base
  - May have had a logical basis at one point
    - Effects of cost shift and fee for service erased their logical origin
    - Hard to adjust them without creating risk or unnecessary reward
    - Existing charges in the hospital departments receive the % increase
    - Growth in an area w/ high prices provides opportunity to reduce
      - CAH high percentage of fixed expense
      - No volume growth, near impossible to fix without reducing your bottom line
- New charges are set with some logic.
  - Use Medicare provider and/or hospital fee schedules
  - Schedule price marked up based on expected reimbursement and costs
  - We compare draft pricing to 50th percentile of national pricing database
- As services materially change we will revisit the charges and reset if possible
- We submit and review Act 53 data annually and do what we can to improve

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Health Care Advocate Questions #9

For the hospital's inpatient services, please provide your all-payer case mix index, number of discharges, and cost per discharge for 2014 (actual) through the present (2017 budget and projected) and 2018 (budget).

	FY14	FY15	FY16	BUDGET FY17	PROJECTED FY17	BUDGET FY18
ALL PAYER CASE MIX INDEX	1.2370	1.1533	1.0638	1.1200	1.1074	1.1100
DISCHARGES	916	1,073	977	943	1,003	996
COST PER (ADJUSTED) DISCHARGE	$ 10,027	$ 10,107	$ 13,036	$ 13,094	$ 12,440	$ 12,883

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Questions?

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